Summary of the Agreement between the U.S. Department of Justice and the State of Vermont and Progress Made By VSH to Date

DATE: January 24, 2007

General Terms

The United States Department of Justice ("DOJ") conducted an investigation of Vermont State Hospital ("VSH") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. §1997. In conformity with CRIPA, this Agreement represents a voluntary effort by the State to meet the concerns raised by DOJ's investigation. The Agreement states that nothing in it shall be construed as an admission of liability.

The Agreement acknowledges that, since the United States issued the July 5, 2005 Findings Letter, the State has made progress in remedying the problems the United States identified in the Findings Letter. The parties agree it is in their mutual interests to avoid litigation and that this Agreement is in the best interests of VSH residents.

On July 21, 2006, the parties filed the Agreement, together with a Complaint and Motion to conditionally dismiss the Complaint, in the United States District Court for the District of Vermont. (Fed. R. Civ. P. 41(a). The Court granted the motion. The case will remain on the Court's inactive docket, during the term of the Agreement. From time to time, the Court may hold, at the request of either party, status conferences to informally resolve disputes between the parties, if any, until the Agreement terminates.

Terms of the Agreement

1. Timeframes: The Agreement terminates in four years from the effective date, but can terminate sooner if the State can demonstrate full compliance before that time.

2. Compliance: The parties agreed to the appointment of Dr. Mohamed El-Saabawi and Dr. Jeffrey Geller as the experts to monitor the State's implementation of the Agreement. The Monitors shall have the authority to independently assess the State's compliance with the Agreement. Every six months, the Monitors shall provide the State and the DOJ with a single written report regarding the State's implementation efforts and its compliance with the terms of this Agreement. The State will take timely action to remedy any deficiencies cited in the report.

3. Access: DOJ shall have unrestricted access to, and shall, upon request, receive copies of any information relating to the implementation of this Agreement, except where covered by attorney work product protections, attorney-client privilege, or peer review.

4. Integrated Treatment Planning: Each patient shall receive treatment coordinated by an integrated team consisting of the patient, the treating psychiatrist, nurse and social worker, and, as clinically appropriate, the patient's family, guardian, advocates, pharmacist and other staff. This team will develop a treatment plan that is specifically tailored to the individual patient's needs. These treatment plans will be revised as appropriate to reflect the patient's needs, goals and objectives. Policies and/or protocols shall be in place to monitor compliance.

   Progress Made**:**
   - Timely completion of the Initial, Preliminary, Comprehensive, and Weekly Treatment Plans are audited on a weekly basis, with feedback loop to treatment team staff.
   - Timelines for completion of treatment plans meet the Agreement requirements.

- Core Treatment Team membership established
- Discipline specific assessments provided to Treatment Team on a timely basis
- Patients invited to attend Treatment Planning meetings
- Patient input included in Treatment Plans
- Treatment Plan reflects active treatment
- Treatment Plan makes determinations about least restrictive environment
- Nursing Kardex has been revised
- Patient transfer form updated
- Consultation and Referral form created
- A team, comprised of VSH and FAHC clinical leadership, is developing a treatment planning template and companion manual consistent with the DOJ requirements.
- Jeffrey Geller, MD, the DOJ monitor and an expert in treatment planning, has consulted extensively to the work group, returned in September to participate in training of members of the VSH treatment teams, and to contribute to the development of the Treatment Planning Policy.
- Training on Treatment Planning; October '06
- Treatment Planning Policy advanced by VSH Policy Committee to VSH Governing Body for consideration
- Treatment Planning Policy approved by the VSH Governing Body; November '06
- Guidelines for Treatment Planning; implemented December '06
- Treatment Planning form; implementation January 1, '07

Integrated Treatment Planning Work in Progress and Earliest Possible Time Frames:

- Treatment Plan consistently reflects Treatment Team assessments including history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history; January '07
- Consistent consideration of medication and its effects; January '07
- Intervention services available to Treatment Team in order to create individualized treatment goals/ objectives; January '07
- Consistent use of behaviorally specific goals and interventions; January '08
- Consistent inclusion of multi-disciplinary assessments; January '08
- Consistent inclusion of biochemical and psychosocial factors; January '08
- Consistent consideration of Age, Gender, Culture, Race, and treatment adherence; January '08
- Therapeutic interventions consistently tied to each goal and objective; January '08
- Assessments, diagnoses, and medications consistently justified clinically; January '08
- Treatment Plan consistently integrate all services provided; January '09
- Timely Treatment Plan review and modification of coordinated care; January '09
- QA system developed to track and trend Treatment Planning; data collection will correspond with the phased implementation of the necessary elements; beginning January '07

5. Mental Health Assessments: Promptly after admission at VSH, each patient shall receive an assessment of the condition responsible for the admission. This assessment shall include an investigation into the past and present medical, nursing, psychiatric and psychosocial factors bearing on the patient's condition. Patients referred for a psychological assessment and/or a rehabilitation assessment shall receive such assessment in a timely manner. Each patient shall receive a social history assessment. Protocols shall be in place to monitor compliance.

Progress Made**:**

- VDH has entered into a contract with Fletcher Allen Health Care to provide psychiatrists that meet the requirements for core faculty at UVM.
- The admission assessment forms for all clinical disciplines (psychiatrist, nursing, social work) and the psychiatric reassessment forms were revised early in 2005.
- A daily assessment for each acute patient's risk of harm and risk of elopement has been initiated and tied to patient privilege level
- AIMS assessment in place to monitor possible symptoms of Tardive Dyskenesia
- Diagnostic protocols have been implemented
- NOS diagnoses tracked and assessed
- Neurological screening embedded in Physician admission assessment
- Rehabilitation assessment and Substance Abuse assessment
- Medical Director provides a more rigorous assessment of psychiatric diagnosis

Work in Progress and Earliest Possible Timeframes:

- Rehabilitation assessment; January '07
- Substance Abuse assessment; January '07
- Psychological assessment; January '08
- Assessments are consistently clinically justified; January '08

6. Discharge Planning and Community Integration: Beginning at admission, VSH shall address particular considerations for each patient's discharge to the most integrated, appropriate setting. This discharge plan will be a fundamental component of each patient's treatment plan and will include the patient's active participation, where appropriate. Discharge planning shall not conclude until the patient has been discharged. VSH shall develop a quality assurance system to monitor compliance.

   Progress Made**:**

   - The psychosocial assessment completed by the social worker at the time of admission was altered to highlight information specific to the patient's eventual discharge.
   - A discharge data base, maintained and updated at least weekly by the Social Workers, has been created and documents existing resources and barriers to each patient's successful discharge.
   - Consideration of factors specific to discharge planning has been embedded into the treatment planning process.
   - An Aftercare Referral Form which documents and demonstrates collaboration between VSH and Community Agencies has been implemented.
   - A Pre-Placement and Short Visit weekly update form which documents collaborative treatment planning between VSH Social Work staff and Community Hospitals/ Agencies has been implemented.
   - A Utilization Review group, incorporating staff from VSH and from the Division of Mental Health, has been formed to regularly review the treatment status of all hospitalized patients and to review and problem-solve anticipated and existing barriers to discharge.
   - The standard of care has been elevated by mandatory clinical discussions at the time of discharge between VSH psychiatrist of record and the psychiatrist providing care in the community placement.
   - Implemented protocols to identify and assess dually diagnosed patients.

- Hired additional Social Worker
- Revised Discharge Planning Policy

Work in Progress and Earliest Possible Timeframes:

- Admission assessment forms for Psychiatrists and Social Workers consistently include consideration of discharge planning elements; July '07
- Treatment Planning consistently include discharge planning elements; July '07
- Discharge database upgraded to include DA barriers and to run automatic reports; January '08

Specific Treatment Services: Protocols and/or policies shall be in place to monitor specific physician practices regarding psychiatric care. Protocols and/or policies shall be in place to monitor the safety, effectiveness and appropriateness of all psychotropic medication use. Individual patients identified with a substance abuse disorder shall be provided with appropriate services consistent with inpatient treatment needs. Adequate and appropriate psychological services shall be provided to individuals who require such services. Protocols and/or policies shall be in place to monitor specific pharmacy services.

Progress Made**:**

- Implemented a system through which nurses and physicians are able to document medication errors and adverse effects attributed to medications. Implemented methods of investigating and aggregating these events.
- Formulary revised to provide broad array of pharmacologic treatment
- Implemented a mechanism for the pharmacist to identify simultaneous use of more than one antipsychotic medication.
- PRN medications require affirmative orders within 30 days
- The legislature has provided financial resources to VSH to purchase a pharmacy management software system. The acquisition of this system promises to provide significant improvements in almost all pharmacy services, in the multiple interfaces between pharmacy and patients, physicians, and nurses. Planning is underway between VSH and IT for the implementation of this system upgrade.
- Allocated funding for 22 additional nurse positions
- Converted 6 Psychiatric Technician positions to LPN to reach necessary staffing thresholds for licensed professionals administration of medications
- Hired a full time Substance Abuse Clinician trainee
- Contracted with a Substance Abuse clinician to provide clinical supervision to substance abuse clinician trainee
- Recruitment underway for additional Psychologist
- Preliminary analysis of rehabilitation services
- Implemented American Psychiatric Association clinical practice guidelines for schizophrenia.
- Short term contract with Psychologist with substance abuse expertise assessed co-occurring disorders program and made recommendations for program development; November '06
- Information Systems manager hired and due to start January 15, 2007. Manager will coordinate information systems activities including: pharmacy software for medication management and the on-going development of an electronic medical record.

Work in Progress and Earliest Possible Timeframes

- Menu of clinical services available to Treatment Teams; **January '07**
- Comprehensive analysis and revision of rehabilitation services including assessments; July'07

7. Documentation: Protocols and/or policies shall be in place to set forth clear standards regarding the accuracy, content and timeliness of all progress, transfer and discharge notes.

Progress Made:

- Current practice standards meet CMS regulations
- Implemented new organization for the patient's chart
- More rigorous monitoring of compliance with charting requirements
- Hired unit clerks for medical record maintenance

Work in Progress and Earliest Possible Timeframes:

- Implement FAHC Physician documentation requirements; **July '07**

8. Restraints, Seclusion and Emergency Involuntary Psychotropic Medications: Protocols and/or policies shall be in place or revised to monitor specific enumerated use of seclusion, restraint and emergency involuntary medications. Competency based training shall be required for any staff monitoring patients who are placed in restraints or seclusion. Data regarding the use of restraint, seclusion, and emergency involuntary medication shall be accurate. Competency based training will be provided to all staff involved in the implementation or assessment of restraints, seclusion or emergency involuntary medications.

Progress Made**:**

- Enhanced formal training in the prevention of aggressive behavior and, when necessary, the safe management of aggressive behavior is provided to all direct care staff, and is refreshed annually.
- All documentation forms and processes pertaining to involuntary emergency procedures have been dramatically revised, providing important tracking information and providing prompts to staff to ensure that all legal and regulatory requirements are met.
- Close and ongoing examination of these processes, including the forms, the quality of documentation, the collection and analysis of data, continues.
- Emergency interventions are reviewed daily and consideration is given to altering the treatment plan of the patient.
- Only licensed professionals initiate restraint or seclusion Emergency Involuntary Procedures
- Emergency Involuntary Procedures Policy approved at the November '06 VSH Governing Body Meeting.
- Emergency Involuntary Procedures Policy implemented November '06

Work in Progress and Earliest Possible Timeframes:

- Mechanisms to ensure documentation consistently contains essential clinical content; July '07

9. Protection From Harm: VSH shall require a criminal background check of all employees and volunteers and shall ensure that staff who are mandatory reporters of abuse and neglect understand the reporting requirements.

   Progress Made**:**

- All employees undergo a criminal background check.
- All employees are oriented to the Vermont statute on abuse, neglect, and exploitation of vulnerable adults and to their responsibilities as mandatory reporters.
- All employees have signed an agreement to report instances of suspected abuse, neglect or exploitation
- The Division of Licensing and Protection provides an annual training for employees.

   Work in Progress and Earliest Possible Timeframes

- Modify Mandatory Reporting Policy; VSH Policy Committee April '07
- Administrative protocol for response to reports; April '07
- The Division of Licensing and Protections' Mandatory Reporting training plan on file with VSH; April '07

10. Incident Management: Policies and/or protocols and practices shall be implemented to monitor incident reporting. All staff shall be trained on incident recognition and reporting. Policies and/or protocols shall be reviewed to ensure timely and thorough reporting of incidents to the Division of Licensing and Protection. VSH shall implement a system for the tracking and trending of incidents, and results of actions taken.

    Progress Made**:**

- An Incident Management reporting system developed and staff members trained in its use. Categories of events are documented and investigated.
- Effective monitoring of abuse, neglect, and exploitation includes: tracking and trending of incidents and actions taken
- The Patient Injury reporting form has been modified to include a prompt reminding the writer to consider whether or not injury requires a report to Adult Protective Services.
- Categories and definitions of reportable incidents established and includes: type of incident, staff involved and staff present; individuals involved and witnesses identified; location of event; date and time of event; cause(s) of incident; and actions taken
- Emergency notification of VSH Executive Director and mandatory reporting time frames are in place
- Posted instructions about abuse reporting established on each patient care unit
- Mandatory Reporting Policy in place
- AHS Personnel Policies prohibit retaliatory behavior against any reporter of abuse, neglect or exploitation
- Policy for referral to law enforcement in place
- Mechanisms in place to ensure staff take immediate action to protect patients and remove alleged perpetrators from direct contact with patients

Work in Progress and Earliest Possible Timeframes:

- Modify any policies/protocols/practices that the Department of Justice determines are necessary; April '07

11. Quality Improvement: VSH shall develop and implement quality improvement mechanisms for effective monitoring, reporting and corrective action (where indicated) for substantial compliance of this agreement.

    Progress Made**:**

- Recently expanded membership and increased the frequency of meetings of the Quality Council, and are redefining the responsibilities, meeting structure and overall purpose of this Council.
- *Preliminary* data is being collected, aggregated, reported, and responded to by managers and other VSH staff in the following areas:
  - clinical documentation in the medical record
  - treatment planning
  - incident/event reporting
  - medication errors/adverse medication effects
  - involuntary emergency procedures
  - staff development/training activities

    Work in Progress and Earliest Possible Timeframes:

- Recruitment underway for Quality Assurance nurse to track and trend clinical documentation and practices; final interviews scheduled January 2, 2007.
- Development of quality improvement mechanisms to track and trend each discipline's compliance with the Agreement; work in this area will develop as policies, protocols, training, and general practices evolve

12. Environmental Conditions: VSH shall develop and implement a system to review all units and areas of the hospital to identify any potential environmental safety hazards, including potential suicide hazards. VSH shall develop and implement policies and procedures to provide for appropriate screening of contraband.

    Progress Made**:**

- Numerous improvements to the safety, security, functionality, and aesthetics of the patient care units and other areas of the hospital have been accomplished.
- This work has been funded by legislative appropriations amounting to more than $1,000,000.00 over the past three years, and has been overseen by the Department of Buildings and General Services (BGS).
- Independent safety reviewers have been contracted to provide a comprehensive Safety Review of the hospital on an annual basis.
- Corrective action plans have been implemented to address the problems identified by the reviewers.
- The Restricted Items and Search policy has been revised.
- Incident management system established that tracks and trends variances (unusual incidents)
- New Identification Badges for Hospital staff that clearly identify employee's name and position

- Appointed Safety Officers to perform inspections with developed checklists
- Employee Infectious Disease Policy updated
- Infection Control Manual updated
- Nutritional safety ensured through daily monitoring
- Color coded map of Hospital and Grounds matched to areas defined in Imposition of Restrictions and Patient Privilege Policy
- Patient wardrobes are currently being installed.

Work in Progress and Earliest Possible Timeframes:

- The Hospital Safety Manual is undergoing revision; January '07
- VSH and BGS will develop a formal Interim Life Safety Plan to ensure maintenance and repairs occur within the context of patient safety and security; July '07
- VDH Emergency Preparedness staff will conduct a thorough review of critical functions at VSH and analyze different classes of employees for responsibilities in an emergency; January '08
- VSH/ VDH will partner with DAIL to establish regulatory thresholds and expectations for patient care in emergency situations; July '08

CMS DEFICIENCIES AND PLANS OF CORRECTIONS

AUGUST 2003

Treatment Plans: Policy revised, staff trained in treatment planning; and meetings' times fixed and posted. Plan put in place.

Poor group treatment: Menu of groups created; documentation of participation occurred. Plan put into place.

Contributing legal factors for lengthy hospitalization unclear: Identified populations; tracked patients waiting for court for commitment or medication hearing and average wait time. Plan put in place.

Unit meeting schedules uncoordinated: Consistent unit meeting schedules created and maintained. Plan put in pace.

Patient privileges not uniform across units: Policy revised. Plan put in place.

Failure to document 30 minute checks: Created 30 minute check sheet. Plan put in place.

Lack of clarity between Charge Nurse and Shift Leader: Organizational chart created to reflect leadership and reporting lines. Plan put in place.

Poor nursing plans: Improved Nursing Kardex. Plan put in place.

Staff unfamiliar with motivational strategies: Motivational interviewing added to first year curriculum. Plan put in place.

Re-assessments of long term patients unclear: Policy about periodicity of treatment plan review clarified. Plan put in place.

SEPTEMBER 2003

Behavior plan for self harm not followed: Behavior plans dated and signed by physician. Plan put in place.

Procedures for admitting or returning patients to VSH: Completed personal items inventory. Plan put in place.

Staff needed to be familiar with policies: Informed staff about policies and signed acknowledgement. Plan put in place.

Patient transfers from unit to unit: All transfer required Medical Director's approval. Revised Transfer Policy. Plan put in place.

Levels of Observation: Policy on Levels of Observation revised ensuring physician rationale is documented and nursing assessment occurs prior to request to change level. Plan put in place.

15 minute checks not reliable: Checklist created. Plan put in place.

Inadequate training: Mandatory Suicide Risk Assessment in-service provided. Plan put in place.

JULY 2004

Timely appointments and credentialing: Established protocol and identified responsible staff. Plan put in place.

Physical examinations and medical history requirements: Revised Admissions Policy. Plan put in place.

Autopsy requests: Revised Patient Death Guidelines and created forms for autopsy. Plan put in place.

Patient allergy information: Revised Admissions and Nursing Assessment Policies. Plan put in place.

Kitchen had numerous problems including: unclean; shelving inadequate, improper storage, outdated food, separation of food and paper products, water temperature and sanitization equipment not up to standard: Replaced shelving; developed kitchen checklist and daily reporting standard; installed automated sanitizer; scheduled quarterly inspections from VDH Sanitarian. Plan put in place.

SEPTEMBER 2004

Physician order must include rationale for type of restraint and duration: Developed and NCR form. Physician order accompanies CON; Medical Director review each order and CON; on-going audit. Plan put in place.

April 2006

In February 2006 Licensing and Protection conducted an informal survey of VSH compliance with general hospital regulations. They noted deficiencies that fell below a Conditional level (serious inadequacies preventing certification). There was no survey conducted to measure VSH compliance with psychiatric regulations.

Medical staff credentialing packet for two physicians was incomplete. Missing information given to Licensing and Protection. Plan put in place.

Post Incident Information Form incomplete: Protocol developed to ensure physician signature. Plan put in place.

Nursing crash carts needed more frequent checks: Nursing daily report prompts daily check on carts. Plan put in place.

Alternative meals nutrition inadequate: Dietician will ensure on a daily basis that adequate nutritional content exists for alternative meals. Plan put in place.

Sanitizing liquid does not meet dwell time standard: Dwell time highlighted on bottles; BGS Housekeepers trained. Plan put in place.

Oxygen use with acute patients needed specialist supervision: VSH protocol disallows the use of oxygen for acute care except in medical emergencies and only until such time as the patient is transferred to a general hospital. Plan put in place.